CENTER FOR
PELVIC HEALTH AND WELLNESS

Patient Name: Date:

Chief Complaint: I am concerned about the following:

□ **Vaginal Bulge/Prolapse** □ **Urinary Control Issues** □ **Bowel Issues** □ **Urinary Tract Infections**

□ **Pelvic Pain/Pelvic Floor Dysfunction** □ **Blood in the Urine** □ **Painful Bladder Syndrome/IC**

□ **Other**

_____

Bothersome Urinary Symptoms: I don't have any bothersome urinary symptoms- *skip to the next section.*

□ Urinary Frequency Urinate every _____ hours

□ Wake up to urinate at night _____ times per night

□ Do wake up wet? □ Yes □ No

□ Urgency (strong sense of needing to rush to bathroom)

□ Every time I need to urinate □ _____ % of the time

□ Do you ever leak before your get to the bathroom/toilet?

□ Yes □ No Leak _____ % of the time

□ When I leak one the way, it is:

□ Drops/Dribbles □ Gush □ Flood (lose it all)

□ What worsens your urgency?

□ Caffeine □ Exercise □ Arriving home □ Standing up

□ Sexual activity □ Alcohol □ Other _____

□ Do you leak urine with activity?

□ Coughing □ Sneezing □ Laughing □ Exercise □ Lifting

□ Sexual activity □ Walking □ Running □ Jumping

□ When I leak with activity, it is:

□ Drops/Dribble □ Gush □ Flood (lose it all)

□ I wear ____ pads per day. Type _____

□ Do you dribble urine after you have urinated? □ Yes □ No

□ Do you have pain/burning with urination □ Yes □ No

□ Feel trouble emptying bladder □ Yes □ No

□ Do you push to empty your bladder □ Yes □ No

□ My symptoms started ____ weeks ____months ____years ago

Pelvic Organ Prolapse: □ I don't have a feeling of a bulge or pressure in my vagina- *skip to the next section.*

Do you feel a sense of pelvic pressure or bulge coming out of your vagina? □ Yes □ No

These symptoms started ____ weeks ____ months ____ years ago

I feel a pressure or bulge □ Sometimes □ Most of the time □ Constantly

Does this pressure/bulge affect your ability to do your daily activities? □ Yes □ No

Does this pressure/bulge affect your ability to urinate? □ Yes □ No

Do you ever have to push on the bulge to urinate or have a bowel movement? □ Yes □ No

Do you avoid sexual activity due to the pressure or bulge? □ Yes □ No

Do you avoid sexual activity due to the pressure or bulge? □ Yes □ No

Do you have pain as result of your pressure or bulge? □ Yes □ No

If surgery is an option for this issue, do you want it? □ Yes □ No

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Urinary Tract Infections: I don't have any issues with urinary tract infections- *skip to the next section.*

When you have a urinary tract infection, what are your symptoms?

□ Bladder pain □ Burning upon urination □ Lower abdominal pain □ Urinary frequency/urgency
□ Blood in the urine □ Fatigue □ Fever/Chills □ Nausea/vomiting
□ Confusion □ Other _____

When was your last UTI? _____ How many UTIs have you had in the last year? _____
Do you think sex is a trigger? □ Yes □ No Do you think stool (smudges/smearing) is a trigger? □ Yes □ No
Did you have UTIs as a child? □ Yes □ No Have you ever been hospitalized for a UTI or kidney infection? □ Yes □ No
What has worked for you in the past? _____

Hematuria: I have not been told or seen blood in my urine – *skip to the next section.*

Who told you that you have blood in the urine? _____ Was it on a routine urinalysis? □ Yes □ No
When did you see blood in the urine? _____
Have you been exposed to or had any of the following?
□ Prolonged chemical use (such as paint or solvents) □ Chemotherapy □ Radiation
□ Tuberculosis □ Second hand smoke □ Tobacco

Pelvic Pain: I don't have any issues with pelvic pain – *skip to the next section.*

Check all areas where you have pain or pressure:
□ Suprapubic (above the pubic bone) □ Middle Abdomen □ Groin area
□ Tail bone or sacrum □ Right kidney area (mid back) □ Outer vagina
□ Urethra □ Left kidney area (mid back) □ Deep vagina
□ Low back □ Pubic bone □ Other _____

Check all areas that describe your pain:
□ Sharp □ Cramping □ Stabbing □ Stinging
□ Burning □ Throbbing □ Dull □ Aching
□ Other _____

Is your pain ever related to or get worse with – check all that apply.
□ Sitting □ Ovulation □ Menses □ Exercise
□ Bowel movements □ Urination □ Movement □ Increased fluid intake/full bladder
□ Acidic foods □ Sexual activity □ Caffeine □ Spicy foods
□ Alcohol □ Stress □ Other _____

What makes your pain better? _____

Past Studies or Tests: Check all studies or tests that you have had before.

□ Urine analysis □ Urine cytology □ Bladder biopsy
□ Ultrasound □ Urodynamic testing □ Intravenous pyelogram (IVP)
□ MRI of abdomen/pelvis □ CT scan of abdomen/pelvis □ Cystoscopy (look into the bladder)
□ Sexually transmitted disease □ Potassium sensitivity testing □ Other _____

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Please mark all things you have used or are currently using for your pelvic health issues:			
	Previously used	**Currently used**	**Was it helpful?**
Cranberry Juice	□	□	□ Yes □ No
D Mannose	□	□	□ Yes □ No
Low acid diet	□	□	□ Yes □ No
Alcohol avoidance	□	□	□ Yes □ No
Caffeine restriction	□	□	□ Yes □ No
Reduced fluid intake	□	□	□ Yes □ No
Kegel Exercises	□	□	□ Yes □ No
Pelvic physical therapy	□	□	□ Yes □ No
Vaginal estrogen/hormone cream	□	□	□ Yes □ No
Hormone replacement therapy	□	□	□ Yes □ No
Pyridium/Urogesic blue/Uribel	□	□	□ Yes □ No
Tricyclic antidepressants (Amitriptyline)	□	□	□ Yes □ No
Gabapentin/Lyrica/Cymbalta	□	□	□ Yes □ No
Oxybutinin (Ditropan)	□	□	□ Yes □ No
Oxybutinin Gel (Gelnique)	□	□	□ Yes □ No
Oxybutinin Patch (Oxytrol)	□	□	□ Yes □ No
Tolteridine (Detrol)	□	□	□ Yes □ No
Fesoteridin (Toviaz)	□	□	□ Yes □ No
Trospium (Sanctura)	□	□	□ Yes □ No
Solifenacin (Vesicare)	□	□	□ Yes □ No
Antihistamines (Atarax, Benadryl)	□	□	□ Yes □ No
Valium/Xanax/Ativan	□	□	□ Yes □ No
Elmiron	□	□	□ Yes □ No
NSAIDS (Advil, Naproxen)	□	□	□ Yes □ No
Opioid analgesics	□	□	□ Yes □ No
Corticosteroids	□	□	□ Yes □ No
SSRIs (Prozac, Zoloft, Paxil)	□	□	□ Yes □ No
Daily suppressive antibiotics	□	□	□ Yes □ No
Postcoital antibiotics (after sex)	□	□	□ Yes □ No
Nitrofurantoin (Macrobid)	□	□	□ Yes □ No
Bactrim (Sulfa)	□	□	□ Yes □ No
Penicillin/Amoxicillin/Augmentin	□	□	□ Yes □ No
Cephalosporins (Keflex)	□	□	□ Yes □ No
Doxycycline/Tetracycline	□	□	□ Yes □ No
Ciprofloxacin/Levafloxacin	□	□	□ Yes □ No
Pessary use	□	□	□ Yes □ No
Laser or radiofrequency	□	□	□ Yes □ No
Acupuncture	□	□	□ Yes □ No
Bladder instillations	□	□	□ Yes □ No
Posterior tibial nerve stimulation	□	□	□ Yes □ No
Botox to pelvic floor	□	□	□ Yes □ No
Botox to bladder	□	□	□ Yes □ No
Trigger point injections	□	□	□ Yes □ No
Vaginal muscle relaxants	□	□	□ Yes □ No
Hydrodistension	□	□	□ Yes □ No
Sacral nerve stimulation/InterStim	□	□	□ Yes □ No
Other _____	□	□	□ Yes □ No

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Bowel Concerns: □ I don't have any issues with bowel movements/constipation/loss of stool– *skip this section.*

Directions: These questions will ask you if you have certain bowel symptoms and, if you do, how much they bother you. While answering, please consider your symptoms **over the last 3 months.**

1. Please choose which stool type is the *most* like the shape of your stools - [ ] Bristol Stool image

Type 1	Type 2	Type 3	Type 4	Type 5	Type 6	Type 7
❑	❑	❑	❑	❑	❑	❑
Separate, hard lumps like nuts (hard to pass)	Sausage-shaped but lumpy	Like a sausage, but with cracks on the surface	Like a sausage or snake, smooth and soft	Soft blobs with clear-cut edges	Fluffy pieces with ragged edges, a mushy stool	Watery, no solid pieces, entirely liquid

1. How many bowel movements do you have typically _____ per day _____ per week
2. Do you feel you have to strain to have a bowel movement? ☐Yes ☐No
3. Do you feel you have not completely emptied your bowels at the end of a bowel movement? ☐Yes ☐No
4. Do you usually have pain when you pass your stool? ☐Yes ☐No
5. Do you have bleeding with bowel movements? ☐Yes ☐No
6. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? ☐Yes ☐No
7. Do you have issues with diarrhea? ☐Yes ☐No
8. Do you ever lack the urge to have a bowel movement? ☐Yes ☐No
9. Do you ever have accidental gas or bowel leakage? ☐Yes ☐No
    a. What is the type and amount of gas or stool lost (check all that apply)

❑ Smearing in underwear ❑ Small amounts of liquid stool ❑ Large amounts of liquid stool
❑ Loss of gas ❑ Small amounts of solid stool 10. Large amounts of solid stool

    a. Do you wear a pad for this issue? ☐Yes ☐No
    b. Do you adjust your lifestyle because of concerns for possible accidental bowel leakage (for example: avoid going out, avoid certain foods, avoid sex)? ☐Yes ☐No
11. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? ☐Yes ☐No
12. Do you have bloating? ☐Yes ☐No
13. Stomach cramps? ☐Yes ☐No
14. Rectal burning during or after bowel movements? ☐Yes ☐No
15. Feeling like you had to have a bowel movement but couldn't? ☐Yes ☐No

Have you had the following?

❑ Anal fissure ❑ Hemorrhoids